Jefferson
School of Population Health

11th National Quality Colloquium

Boot Camp 1

August 13th, 2012

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JEFFERSON
1824

Tobacco Smoke Enema (1750s-1810s)
The tobacco enema was used to infuse tobacco smoke into a patient's rectum for various medical purposes, primarily the resuscitation of drowning victims. A rectal tube inserted into the anus was connected to a fumigator and bellows that forced the smoke towards the rectum. The warmth of the smoke was thought to promote respiration, but doubts about the credibility of tobacco enemas led to the popular phrase "blow smoke up one's ass."

This Old Tool has been reintroduced in Washington D.C. by the New Administration.
Are you starting to feel it

INSIDE THIS WEEK: A 14-PAGE SPECIAL REPORT ON AGEING

The Economist

Iran's agony

The mystery of Mrs Merkel

Asia's consumers to the rescue?

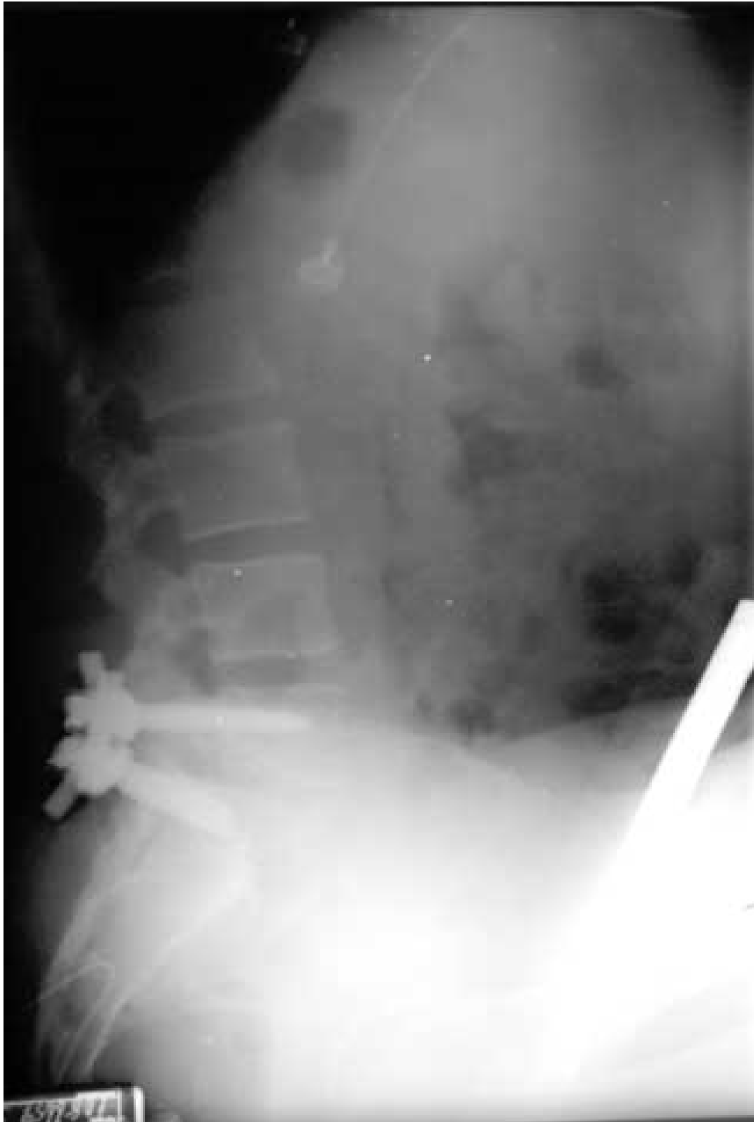
The Greeks and those marbles

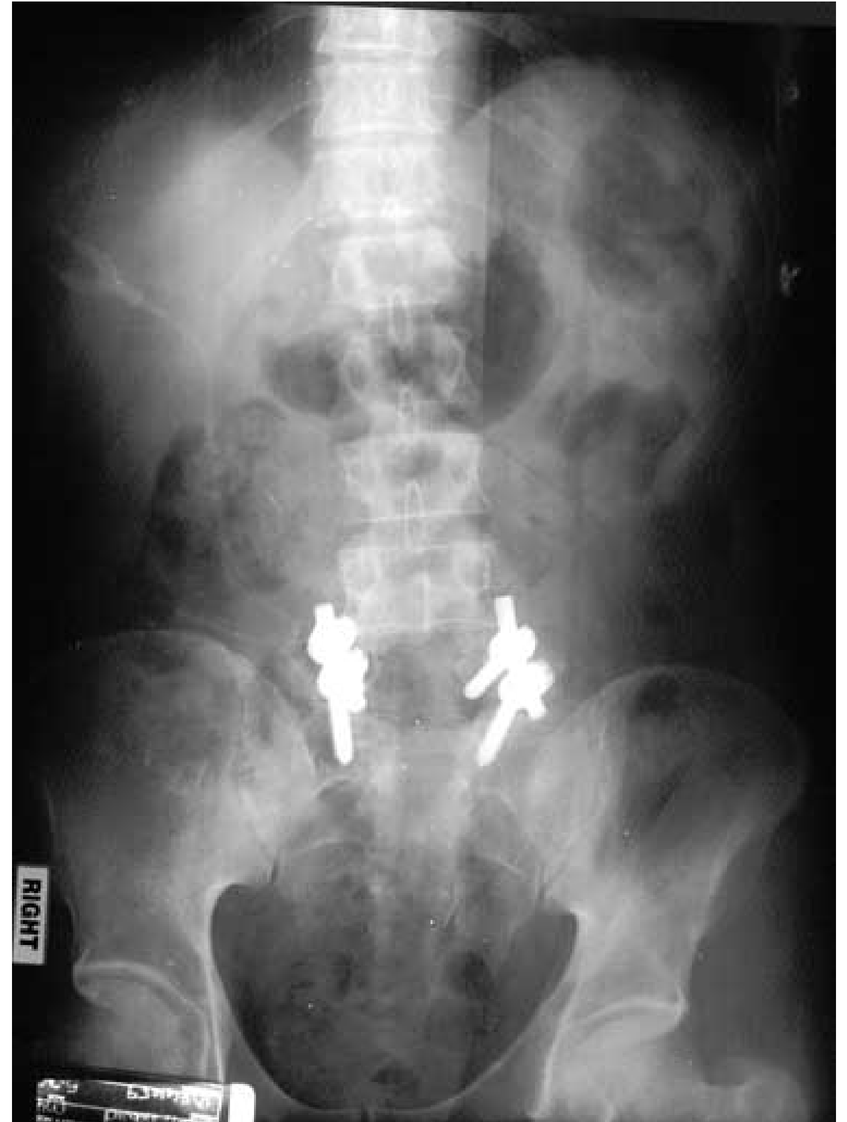
Evolution and depression

JUNE 27TH–JULY 3RD 2009 Economist.com

Reforming health care

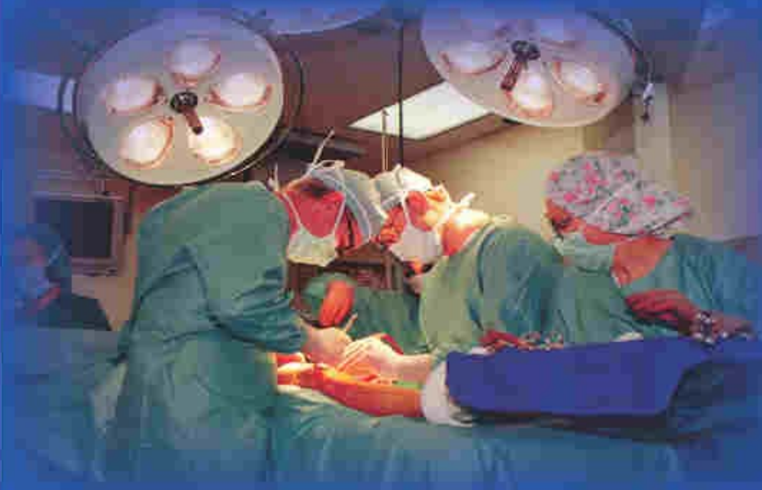
This is going to hurt




RIGHT

Total Hip and Knee Replacements

FISCAL YEAR 2002: JULY 1, 2001 TO JUNE 30, 2002



PHC4

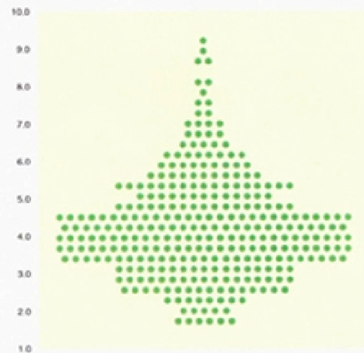
PENNSYLVANIA HEALTH CARE COST CONTAINMENT COUNCIL
JUNE 2005

Center for the Evaluative Clinical Sciences

Regional Variation in Rates of Spine Surgery

Total Spine Surgery

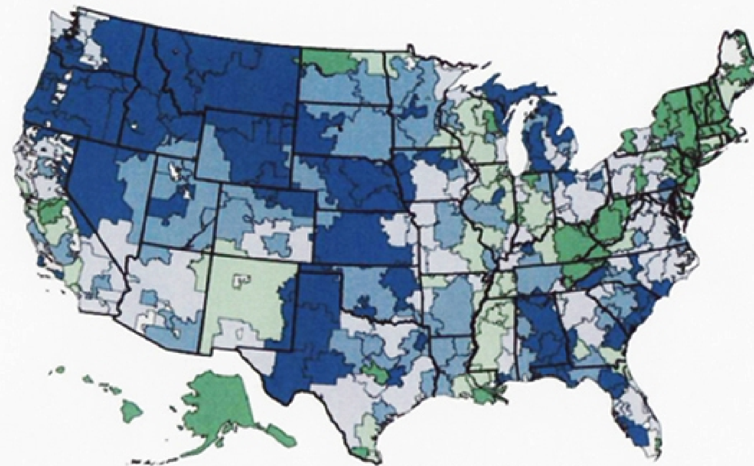
There was substantial regional variation in overall spine surgery rates among Medicare enrollees in 2002-03 (Figure 3). Rates varied by a factor of almost six, from 1.6 per 1,000 enrollees to 9.4. Among the hospital referral regions where rates of spine surgery were highest were Casper, Wyoming (9.4); Mason City, Iowa (9.0); Bend, Oregon (8.7); Boise, Idaho (8.2); and Billings, Montana (8.0). Regions with rates lower than the national average of 4.0 spine surgery procedures per 1,000 enrollees included Honolulu (1.6); Newark, New Jersey (1.7); Paterson, New Jersey (1.8); Manhattan (1.8); and East Long Island, New York (1.8).



Spine surgery per 1,000 Medicare enrollees (2002-03)

Each point represents the rate in one of the 306 HRRs in the United States.

Figure 3. Rates of Spine Surgery Among Hospital Referral Regions, 2002-03



Ratio of Total Rates of Spine Surgery to the U.S. Average
by Hospital Referral Region (2002-03)

- 1.30 to 2.36 (71)
- 1.10 to < 1.30 (56)
- 0.90 to < 1.10 (80)
- 0.75 to < 0.90 (47)
- 0.40 to < 0.75 (52)
- Not Populated

Map 1. Spine Surgery

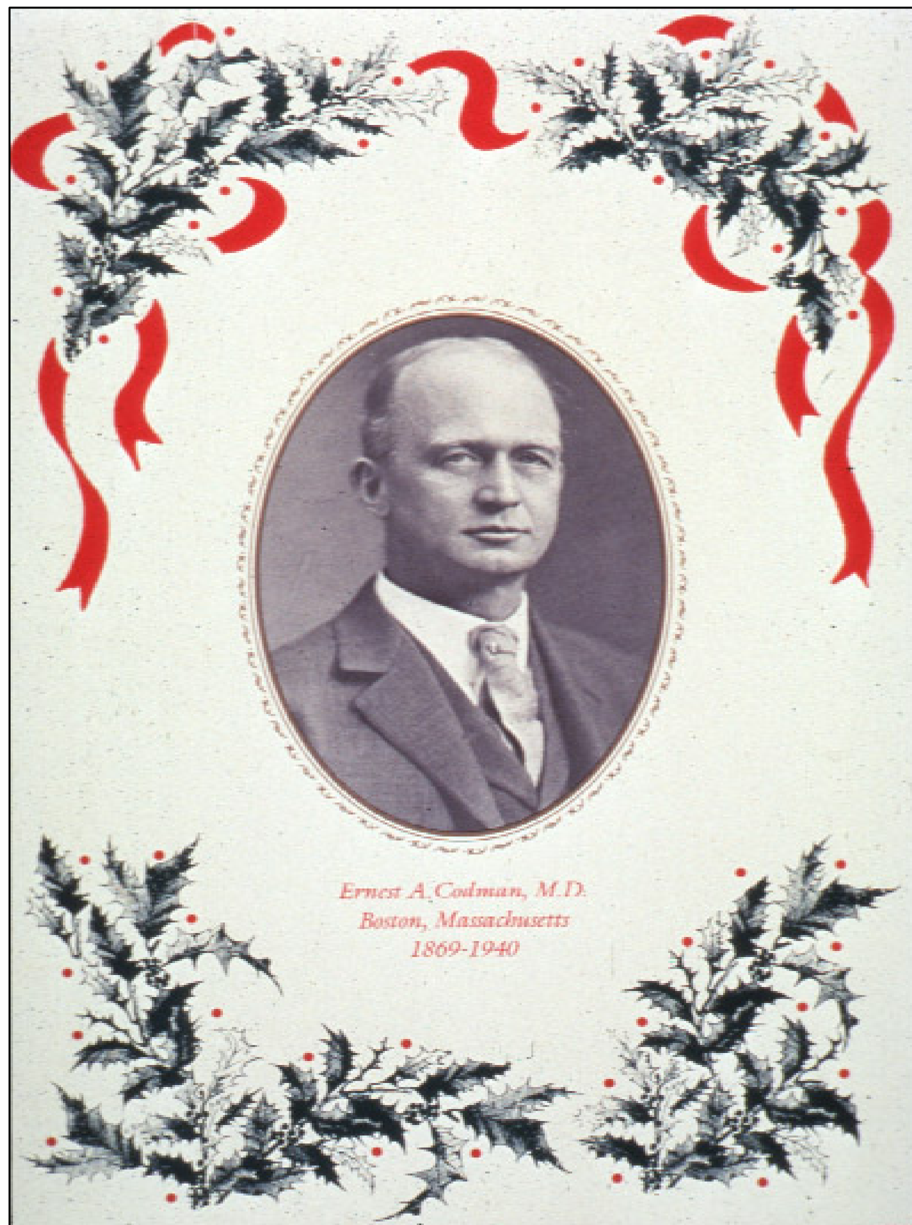
In 71 hospital referral regions, rates of spine surgery were at least 30% higher than the United States average of 4.0 per 1,000 Medicare enrollees. In 52 hospital referral regions, rates were more than 25% lower than the national average.

Jefferson School of Population Health

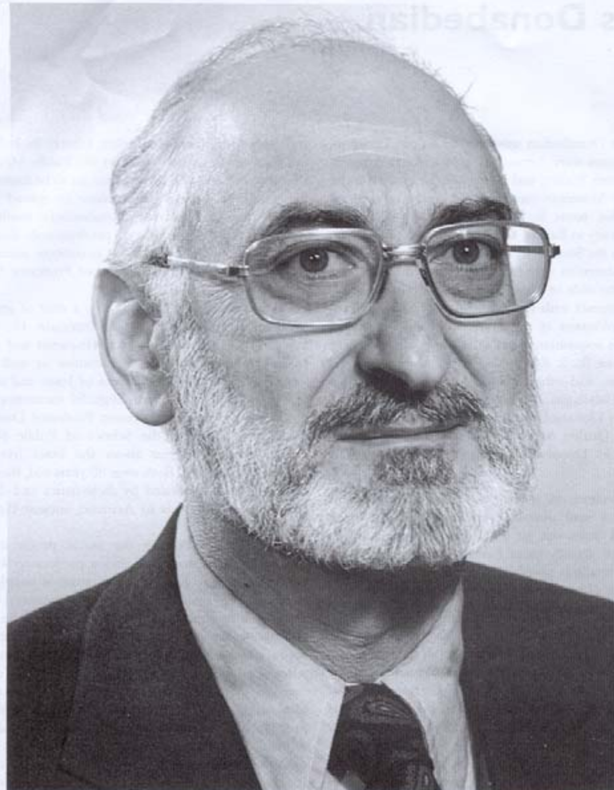
… all hospitals are accountable to the public for their degree of success…

If the initiative is not taken by the medical profession, it will be taken by the lay public.

1918 Am Coll Surg


Ernest A. Codman, M.D.
Boston, Massachusetts
1869-1940

International Journal for Quality in Health Care 2000; Volume 12, Number 6: pp. 451–454



Avedis Donabedian
7 January 1919–9 November 2000

The President, Executive Board, Members and Friends of The International Society for Quality in Health Care and the Editors of the Society's Journal, honour the distinguished life and acclaimed contributions of **Avedis Donabedian**, primary architect of the field of quality in health care and a life Member of ISQua, who died peacefully at his home in Ann Arbor, Michigan, USA on 9 November 2000.

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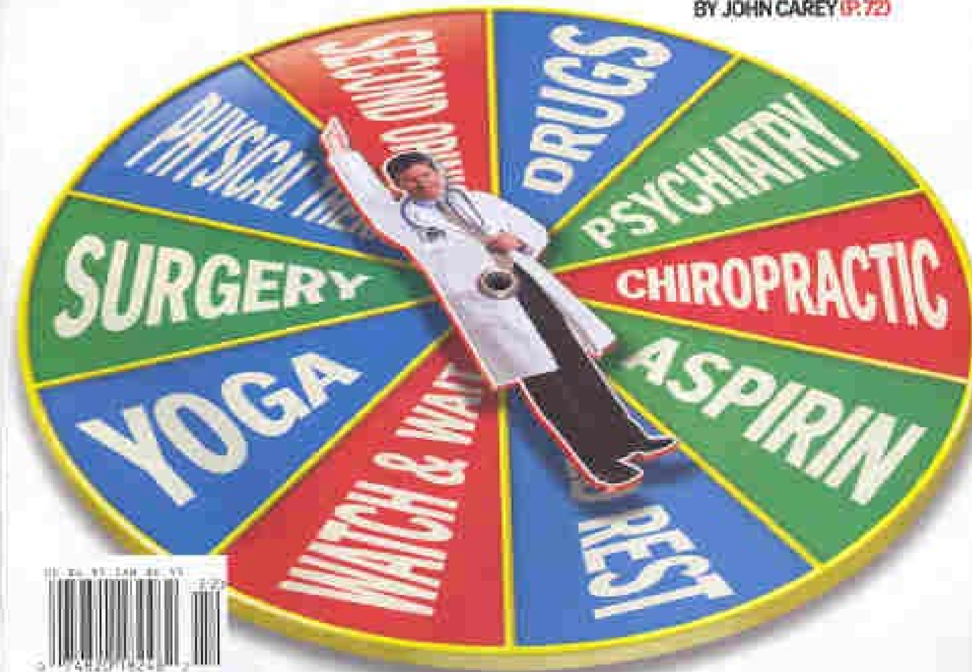
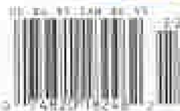
www.businessweek.com

Medical Guesswork

From heart surgery to prostate care, the medical industry knows little about which treatments really work

BY JOHN CAREY (P. 72)





ARE DOCTORS JUST PLAYING HUNCHES?

We expect them to use hard data. But that's not always the best kind of medicine

By CHRISTINE GORMAN

NOBODY PRETENDS MEDICINE IS EASY, BUT IF THERE'S ONE thing we ought to be able to rely on, it's that the doctors looking out for us are doing more than playing hunches. We take certain medicines because they work, right? We go into the operating room for certain procedures because they'll make us well, don't we?

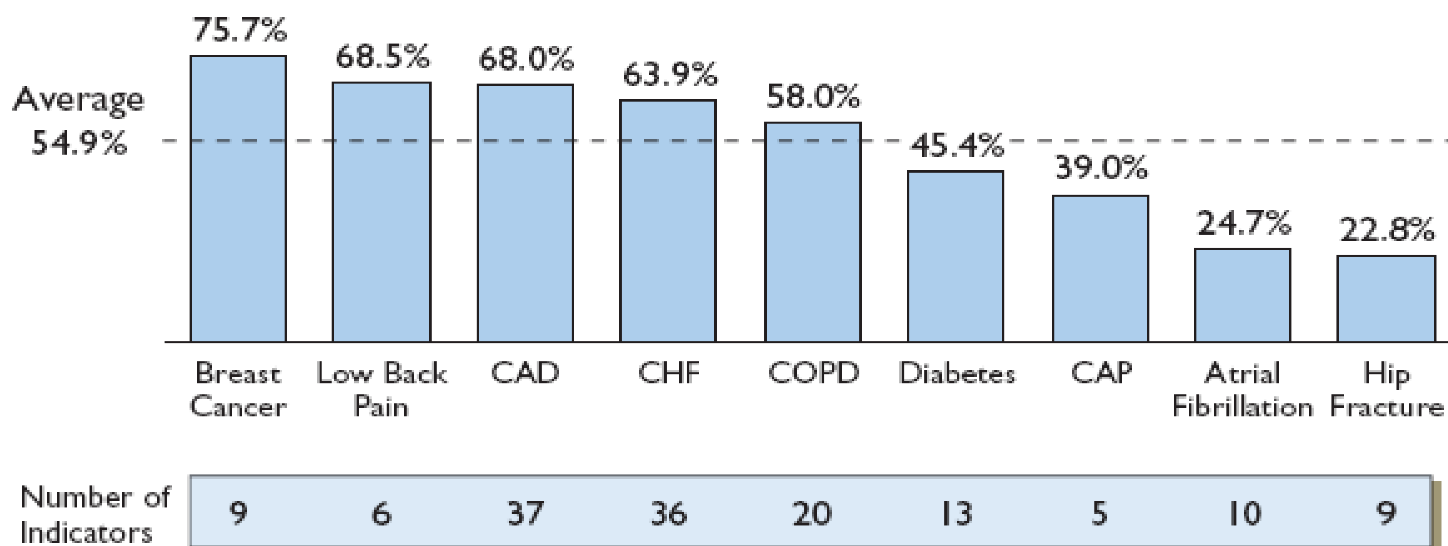
Well, maybe. More and more, however, doctors are making the unnerving case that no matter how reliable a drug or other treatment appears to be, too often there's simply little hard evidence that it would make a long-term difference in a person's quality of life or prolonged survival. Obviously, drugs are tested rigorously to show that they are safe and effective before they are approved by the U.S. and other developed countries. But a clinical study is not the real world, and just because a drug leads to a statistically significant improvement in, say, cholesterol levels doesn't guarantee that the desired effect—a healthier heart and a longer life—will follow. Often your doctor is left to make prescription decisions based at least in part on faith, bias or even an educated guess. That ought to be enough to spook even the least jumpy patient, but the fact is, recognizing just what a roll of the dice medicine can be may be a good thing.

Increasingly, doctors seeking to provide their patients with the best possible care are exploring what is known as evidence-based medicine—a hard, cold, empirical look at what works, what doesn't and how to distinguish between the two. It's not enough to prove that a particular blood test or CT scan really spots cancer, for example. You also need to know whether early detection of that cancer would make a difference in your ability to respond to treatment or it merely means that you would die at the same point but learn about your illness earlier than you would have without the test.

Evidence-based medicine, which uses volumes of studies and show-me skepticism to answer such questions, is now being

> Some things can't be tested; some things are so obvious, they don't need it.”
>
> —DR. PAUL GLASZIOU, director, Center for Evidence-Based Medicine in Oxford, England

Uneven Adherence to the Evidence



Source: McGlynn EA, et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*. June 26, 2003: 2635–2645.

VALUE-DRIVEN HEALTH CARE

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VERSION 1.0 - FEBRUARY 2007

PREPARED BY BAILIT HEALTH PURCHASING, LLC

Available at http://www.leapfroggroup.org/news/leapfrog_news/Purchaser_Guide

Mirror, Mirror on the Wall

How the Performance of the U.S. Health Care System Compares Internationally

2010 Update

Karen Davis, Cathy Schoen, and Kristof Stremikis

June 2010

A World of Hurt

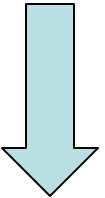

Exhibit ES-1. Overall Ranking

Country Rankings	
Green	1.00–2.33
Yellow	2.34–4.66
Red	4.67–7.00

	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	$3,357	$3,895	$3,588	$3,837*	$2,454	$2,992	$7,290

Note: * Estimate. Expenditures shown in $US PPP (purchasing power parity).
Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, *OECD Health Data, 2009* (Paris: OECD, Nov. 2009).

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FINAL SCORES

By Carlos Osorio, AP
Kevin Harvick: Third win of season.

Harvick is first to get Chase slot

Driver's study of Earnhardt tapes pays off as he wins the Carfax 400. NASCAR, 1, 7C

Monday, August 16, 2010

Glimpse the future of primary health care

Innovative programs counter doctor shortage

By Rita Rubin
USA TODAY

About 65 million Americans live in communities with a shortage of primary care doctors, physicians trained to meet the majority of patients' health care needs over the course of their lives.

How much more difficult will finding a primary care doctor become as a result of the recently passed health care overhaul legislation, which will extend coverage to an estimated 34 million currently uninsured Americans by 2019?

Massachusetts, which in 2006 passed a law that led to nearly universal coverage of its 6.6 million residents, might provide some clues.

In that state, fewer and fewer internists and family practice doctors are taking new patients, and wait times to see family practice doctors are lengthening, according to the Massachusetts Medical Society and the non-profit Massachusetts Health Quality Partners.

Even before Congress in March passed the landmark law designed to make health care more affordable and expand coverage, an aging population and doctors' increasing preference for higher-paying specialties set the stage for a primary care shortage. And what many believe to be an outdated reimbursement system — one that drives

By William Thomas Cain for USA TODAY
Nurse practitioner: Donna Torrisi helped create the Family Practice and Counseling Network.

doctors to schedule office visits when a quick phone call or e-mail might do — doesn't help.

The shortage of primary care doctors could lead to longer waits not only for primary care, but also for specialty care as well as greater use of expensive emergency rooms for non-emergencies, researcher Walt Zywiak of Computer Sciences Corp., an international consulting company headquartered in Falls Church, Va., noted in a July report.

Cover story

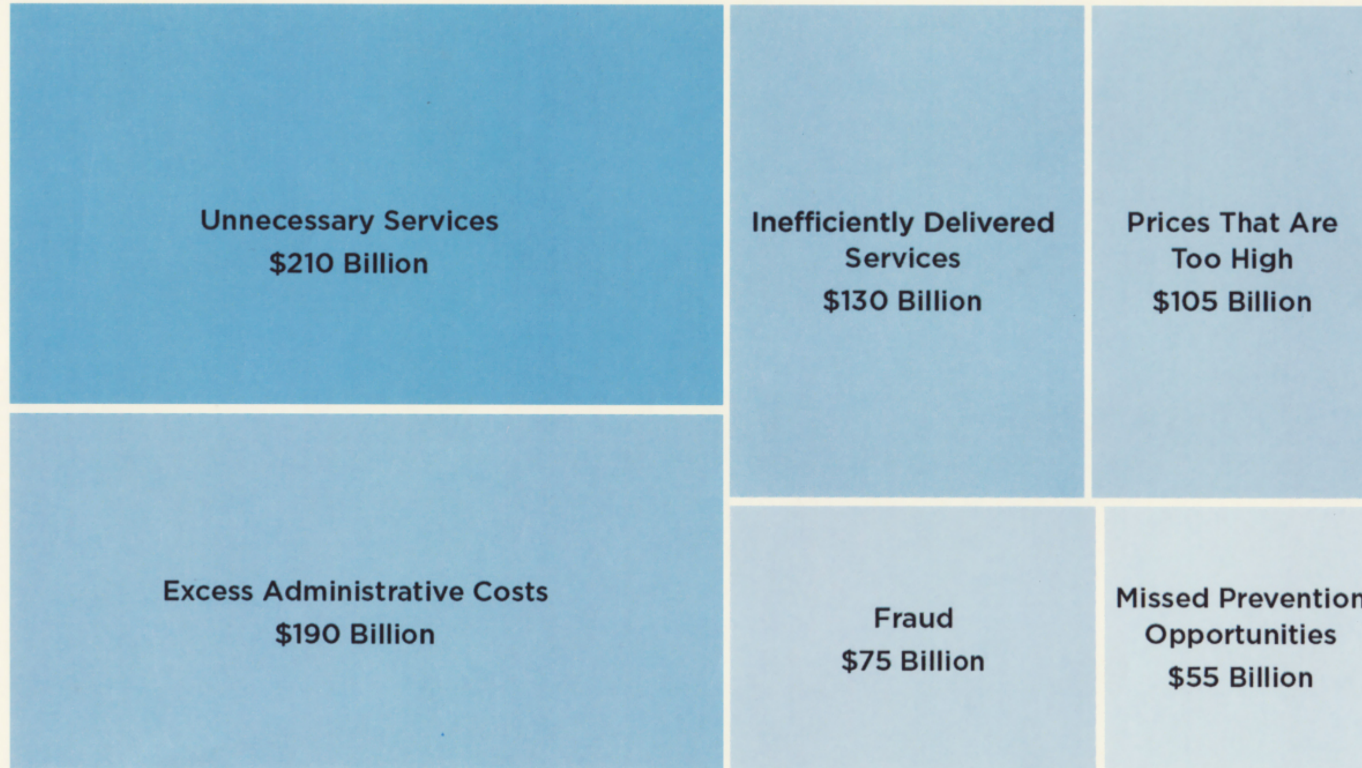
But some innovative programs provide a glimpse of what the future of primary care — a

Please see COVER STORY next page ►

It is possible to improve care and dramatically lower costs.

Berwick Annals 2/98

Domains of Excess Costs



INSTITUTE OF MEDICINE
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Advising the nation / Improving health

Getting to 10%

CARE-RELATED COSTS

Prevent medical errors

Prevent avoidable hospital admissions

Prevent avoidable hospital readmissions

Improve hospital efficiency

Decrease costs of episodes of care

Improve targeting of costly services

Increase shared decision-making

ADMINISTRATIVE COSTS

Use common billing and claims forms

RELATED REFORMS

Medical Liability Reform

Prevent Fraud and Abuse

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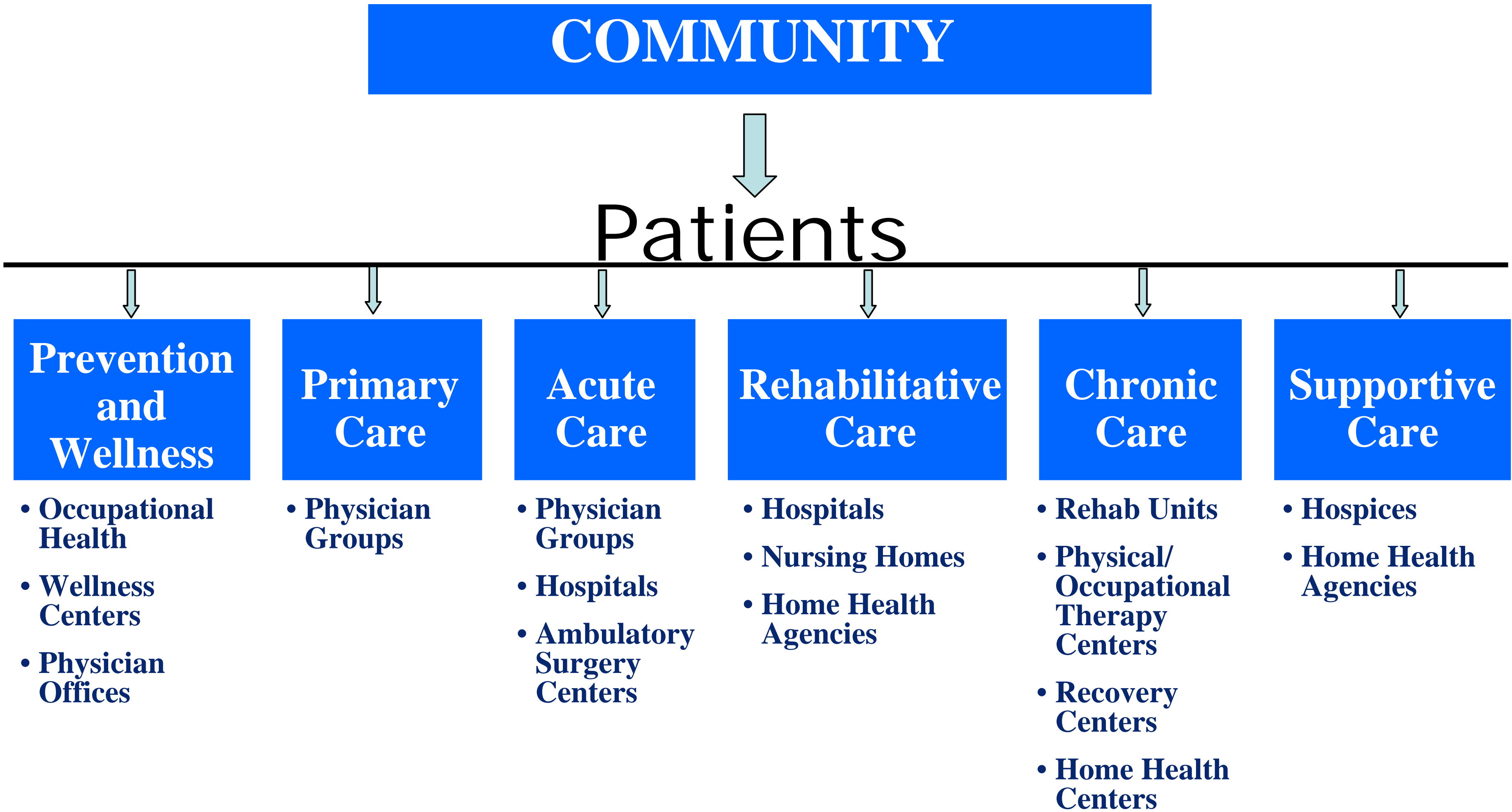
Imperatives of the New Century

- **Accountable for the health status of defined populations**
- **Global Budgets/Targets**
- **Incentives to actively manage clinical care**
- **Incentives to provide a coordinated continuum of care**
- **Incentives for continuous quality improvement**
- **The demand for value**

The Seamless Continuum of Care



Shortell Stages of Integration

- Functional
  - bring partners together
- Physician - System Integration
  - bring together doctor groups
- Clinical integration

What will clinical integration require?

- Centralization of process
- Evidence based medical practice
- Commitment to self evaluation

Cultural Barriers to Integration *(and Industrialization)*

- **Autonomous decision making**
- **Socialization**
- **Uneven evidence about outcomes**
- **Fear of performance assessment**

Definition of Quality Institute of Medicine

"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

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FIRST, DO NO HARM

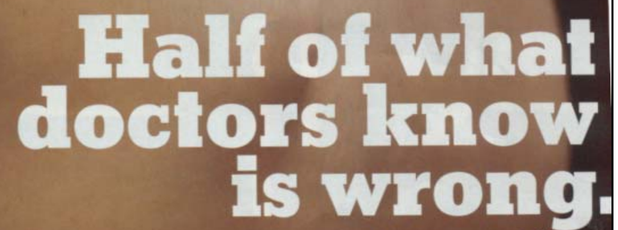
BUILDING A SAFER HEALTH SYSTEM

INSTITUTE OF MEDICINE

The New York Times Magazine

MARCH 16, 2003 / SECTION 6

This War's Medic



Can prevention kill you?

Is it ever O.K. for a doctor to refuse to treat a patient?

Are nurses expendable?

Should the results of an insidious experiment be ignored?

Are men the stronger sex?

What's really responsible for the malpractice morass?

Can old-fashioned treatments still work?

"USA TODAY hopes to serve as a forum for better understanding and unity to help make the USA truly one nation."
—Allen H. Neuharth, Founder, Sept. 15, 1982

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Today's debate: Medical errors

Why do so many still die needlessly in hospitals?

Our view:

Part-voluntary, part-mandatory reporting system can reduce deaths.

When a report came out last week from a private group claiming that nearly 200,000 hospital patients die each year from preventable medical errors, it promptly sparked a fierce controversy.

The estimate was double the number found in a landmark study in 1999 by the Institute of Medicine (IOM), a federal advisory group, and the lead author of that earlier study went on the offensive. He charged that the new report used flawed research methods that inflated the fatalities.

But why argue? The difference alone makes a more telling point: Five years after the IOM report drew front-page headlines and widespread outrage, there still is not even a sure way to measure the problem. And that appalling fact should concern any prospective hospital patient — which is to say, everyone.

This year, Congress is finally doing something, though hardly enough.

Before the end of the year, it is expected to install new incentives for medical personnel to report errors. The new system, already approved by both houses, would allow doctors, nurses and other hospital workers to report mistakes anonymously. Independent analysts would then look for patterns and recommend changes. Lawyers and employers would be kept in the dark.

That's an important step.

Suppose, for instance, that a nurse gives a patient the wrong pill because its name and packaging resemble a drug next to it on the hospital's pharmacy shelf. Neither she nor the pharmacist will want to reveal the error, for fear of being punished or sued. The error likely will recur.

But if they can confidentially report the problem, experts can devise ways to improve the packaging and placement of medicines to reduce the risk of simple human error. Lives will be saved.

Six states that have set up similar procedures have seen a significant increase in reported mistakes.

That's clearly the right way to handle relatively minor mistakes, even when they result in some harm.

Even so, the picture will still be woefully incomplete — and patients will remain at risk — unless the reporting of errors that kill or cause the most serious injuries is made mandatory.

Only 22 states currently have mandatory error-reporting systems. The others rely on hospital-industry watchdogs or malpractice lawyers to be on the lookout for mistakes.

The argument over numbers is proof that leaving the solution to the courts is not a prescription for eliminating deadly errors.

Five years ago, the IOM recommended a two-tiered approach, part voluntary, part mandatory. It is still the most sensible compromise.

The question is why five years have elapsed with so little being done. With tens of thousands dying needlessly every year, the next life at risk may be your own.

Mistakes cost lives

Highlights from a new study of medical errors involving Medicare patients hospitalized from 2000 through 2002:

- Out of 37 million hospitalizations, 1.14 million "safety incidents" occurred.
- 263,864 deaths were directly attributed to the incidents.
- The safety incidents accounted for $8.54 billion in additional Medicare costs.
- Nearly 60% of safety incidents involved the failure to diagnose and treat conditions that developed in the hospital, bedsores and post-operative infections.

Source: HealthGrades' "Patient Safety in American Hospitals" study released July 27

PHYSICAL EXAMINATION

Name: ____________ MR # ____________ Date: ____________

	Weight______ Blood Pressure______ Pulse______ Temp______ Respirations______
General Apparent Age Condition Appearance Race, sex, etc.	WDWN w ♀
Head:	NCAT
EENT:	
Neck:	supple
Breasts:	s̄ masses
Chest & Lungs:	clear
Heart and Vascular:	
Abdomen:	AV AF mobile
Rectal:	no masses
Pelvic:	
Musculoskeletal:	– [illegible]
Neurological:	
Impressions:	

Reviewed by Physician
No change
Treatment Still indicated
________ Attending Physician M.D.
Date/Time: ________

Performed by: ______________________ M.D.
Physician (Intern or Resident)

Section I. Surgical or invasive procedure is scheduled (with right or left specified when laterality is involved), and Pre-Admission Testing sheet is consistent with documentation on current medical record and patient's verbal verification.

Site verified as (circle one): Right Left Bilateral No Laterality

PAT RN Signature

Section II. Surgical or invasive procedure is verified and site has been marked by the physician and is consistent with the patient's current medical record, which must include the H&P and consent.

Site verified as (circle one): Right **(Left)** Bilateral No Laterality

Site verified and marked by Surgeon

Staff Nurse Signature

Patient Identification and Site Verification Immediately Prior to the Procedure

(Procedure Physician Signature below indicates that the surgeon identified the patient immediately prior to surgery with the patient on the OR/Procedure table.)

	Provider(s) Present	Procedure	Side
Circulating/ Assisting Nurse/Personnel		Right heel ulcer debridement with Oasis graft & wound VAC	Left / Bilateral / Right / N/A
Procedure Physician			
Anesthesia Provider			

(Circulating/Assisting Nurse to list name of anesthesia provider, if present. If no anesthesia provider is involved in the procedure, document N/A for Not Applicable. Anesthesia Provider signature, procedure and site will be documented by the Anesthesia Provider on the Anesthesia Record.)

The surgical/procedure team (Surgeon/Procedure Physician, Anesthesiologist, and Circulating/Assisting Nurse/personnel) as listed above has paused to verify the correct patient, procedure and site, and availability of correct implants/special equipment as indicated, by active communication immediately prior to the procedure with the patient on the procedure table. If x-ray films are present, the procedure physician has verified the proper orientation of the films.

Signature – Circulating/Assisting Nurse/Personnel — Date: 2/23/09 — Time: 1526

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The Magazine

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PLUS Enter for a chance to win an iPad
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Feel great. Save money. Have fun.

5 BEST PLACES TO LIVE—ABROAD!
Enjoy paradise on next to nothing
Page 52

Discover Your Inner Genius
Late-blooming artists tell you how

8 signs your marriage is healthy (or not)

Outfox the airlines!
Page 46

Meet the *real* Jane Pauley

Dennis Quaid
A medical mistake nearly killed his infant twins—and inspired a personal mission to save lives Page 48

PLUS
Are you ready for the next market dip?
Page 30

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Journal on Quality and Patient Safety
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August 2007
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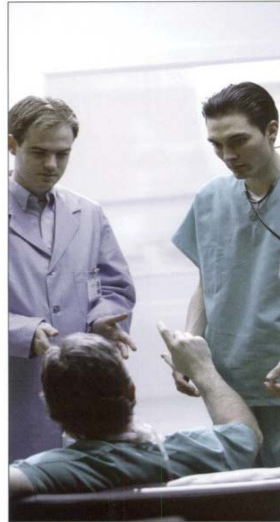

How Medical Errors Affect Physicians

Features

Reporting Systems

- The Emotional Impact of Medical Errors on Practicing Physicians in the United States and Canada

5 Million Lives Campaign

- Miles to Go: An Introduction to the 5 Million Lives Campaign

Teamwork and Communication

- The Continuing Problem of Missed Test Results in an Integrated Health System with an Advanced Electronic Medical Record

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Only 77% wash hands after using the toilet

Advocates are pushing for more frequent scrubbings in health care and non-health care settings.

VICTORIA STAGG ELLIOTT
AMNEWS STAFF

How clean are your hands? How about the person who just shook yours?

Several presentations at last month's Interscience Conference on Antimicrobial Agents and Chemotherapy in Chicago suggested that people not only wash their hands less often than they say they do, but the number who really do appears to be decreasing. Also, improving hand hygiene in the health care setting saves money.

"Hands are great distributors of disease, but hand washing is a great intervention," said Judy Daly, PhD, spokeswoman for the American Society for Microbiology, which organizes this meeting. She is also director of the microbiology laboratory at Primary Children's Medical Center in Salt Lake City.

According to data from observational and telephone surveys by Harris Interactive, which were commissioned by the society as well as the Soap and Detergent Assn. and released at the meeting, 92% of adults say they always wash their hands after using a public restroom. When observed in places such as train stations and sports stadiums, only 77% actually do. This represented a decline from the 83% observed in the 2005 version of this survey.

Significant gender differences also were seen, with only 66% of men soaping up compared with 88% of women. Similar gaps between men and women also were found by other studies that examined the behavior of doctors and health care professionals.

"Very clearly, guys need to step up to the sink," said Brian Sansoni, vice president of communication for the soap association.

This issue has long concerned medical societies, patient safety organizations and public health agencies. The American Medical Association urges everyone to view hand washing as important. Experts suggest, however, that while this activity is important across the board, more payoff may be gained from programs that focus on health care settings.

"The message about improving hand hygiene is a good message to support, but we will naturally see the greatest result in the places where the sickest people are," said Dr. M. Lindsay Grayson, vice chair of Austin Hospital/Austin Health in Melbourne, Australia.

In these venues, the benefit of hand hygiene is increasingly being quantified. For instance, a paper presented by Dr. Grayson found that hand hygiene education for health care professionals along with ensuring that alcohol hand rubs were available significantly reduced the number of methicillin-resistant *Staphylococcus aureus* infections. In turn, this result saved his state's health system more than a million dollars.

"We need a culture change," Dr. Grayson said. "Those who provide care should feel funny walking up to a patient having not used an alcohol-based hand rub. And the patient should feel pretty funny, too."

An Argentinean study also found that upping compliance with hand hygiene recommendations in the intensive care unit reduced the device-associated infection rate from nearly 20% to just shy of 5%. But although researchers say these efforts can pay for themselves, improving hand hygiene comes with significant challenges. In Dr. Grayson's study, the urban institutions did not do as well as the rural ones because of high staff turnover.

The factors that motivate health care professionals to wash more often also might not be the most obvious ones. A study out of the University of Geneva Hospitals in Switzerland found that the opportunity to reduce nosocomial infections did not increase hand washing, but peer pressure and easy access to hand-washing facilities did. ◆

PHOTO BY TED GRUDZINSKI
Judy Daly, PhD, presented the hygiene findings at the Chicago conference.

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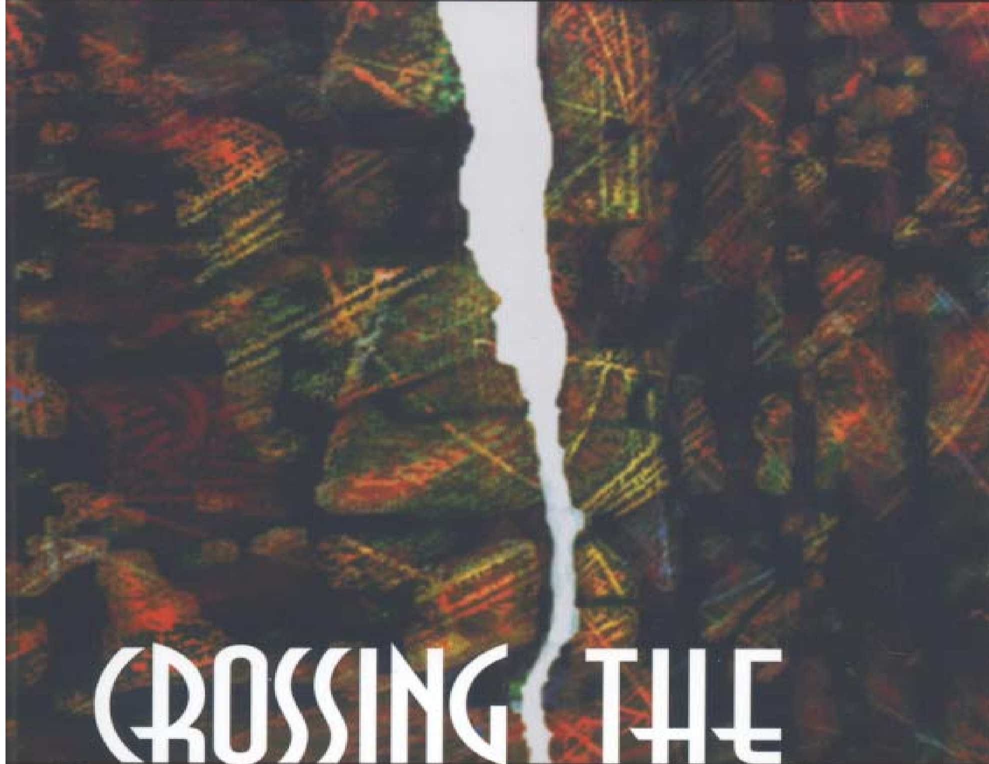
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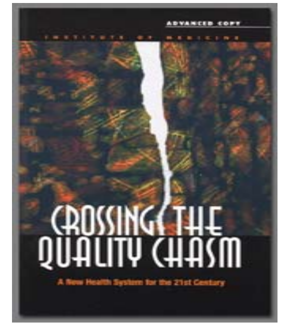
A New Health System for the 21st Century

Institute of Medicine Report 2001



Outlines Key Dimensions of the Healthcare Delivery System:

Safe: avoiding injuries to patients from the care that is intended to help them.

Effective: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).

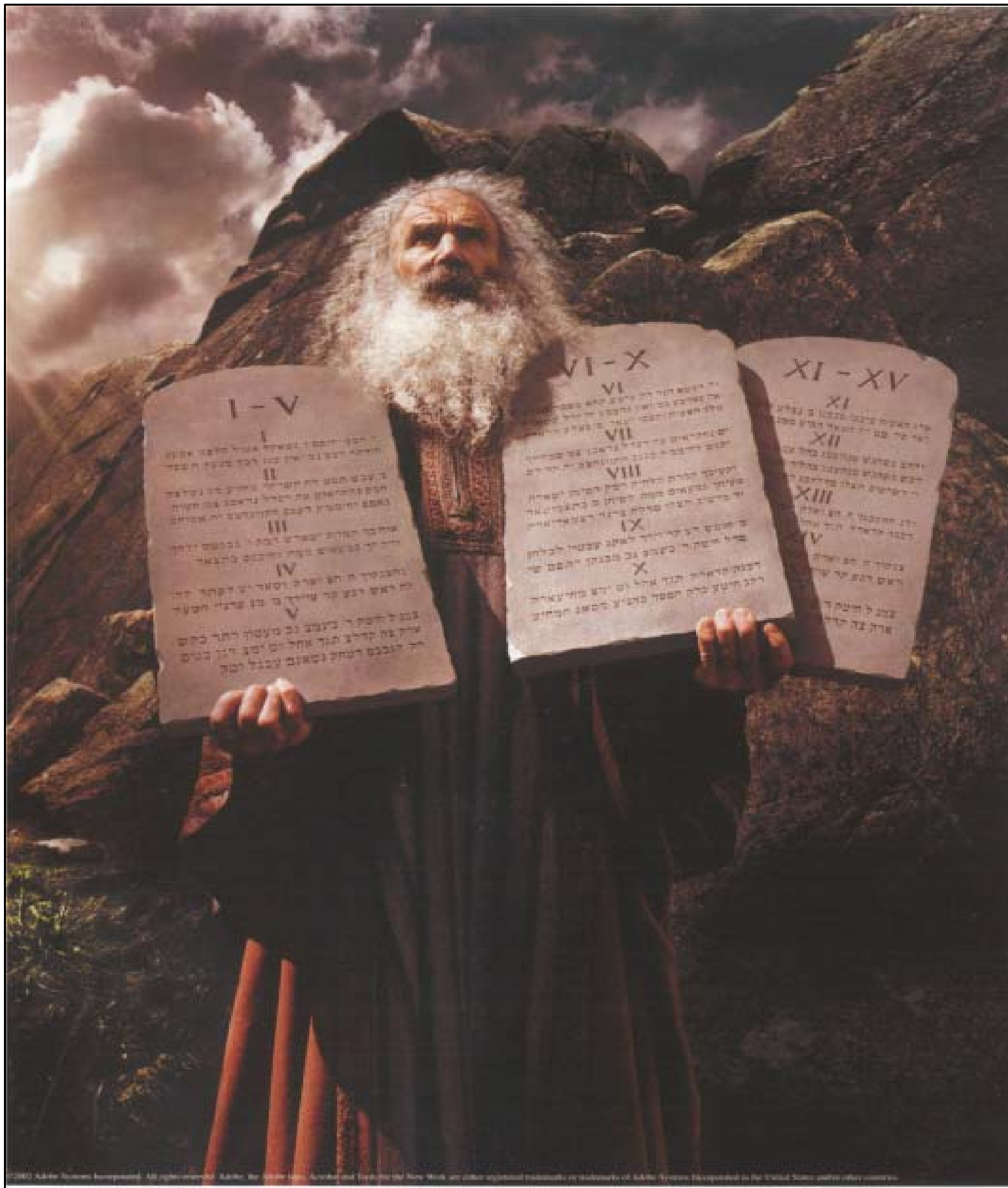
Patient-centered: providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Timely: reducing waits and sometimes harmful delays for both those who receive and those who give care.

Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Efficient: avoiding waste, including waste of equipment, supplies, ideas, and energy.

Source: Institute of Medicine 2001; 5-6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Ten Commandments
Crossing the Quality Chasm

Current Rules

1. Care is based primarily on visits
2. Professional autonomy drives variability
3. Professionals control care
4. Information is a record
5. Decision making is based on training and experience

New Rules

1. Care is based on continuous healing relationships
2. Care is customized according to patient needs and values
3. The patient is the source of control
4. Knowledge is shared freely
5. Decision making is evidence-based

Don Berwick 2002

Ten Commandments (*cont.d*)

Current Rules

6. "Do no harm" is an individual responsibility
7. Secrecy is necessary
8. The system reacts to needs
9. Cost reduction is sought
10. Preference is given to professional roles over the system

New Rules

6. Safety is a system property
7. Transparency is necessary
8. Needs are anticipated
9. Waste is continuously decreased
10. Cooperation among clinicians is a priority

Don Berwick 2002

Safe	Timely	Effective	Efficient	Equitable	Patient-Centered
• **No harm from care** (procedural competence, experience, medical knowledge, evidence based medicine) • **No errors** (anatomy, physiology, pathology, etc..., systems engineering, information systems, cognitive psychology)	• **No delays in acute care** (pathology, process mapping, team function, information systems, procedural competence) • **Access chronic care** (information systems, communications) • **Ongoing preventive care** (epidemiology, surveillance)	• **Curative of acute illness** (basic science, vocabulary, key concepts integrated around biologic homeostasis, pathology, resilience, evidence based medicine) • **Prevention** (epidemiology, evidence based medicine) • **Reduce suffering** (psychology, religion, procedural competence)	• **Cost-benefit analysis** (epidemiology, economics, statistics) • **Reduction of waste** (process engineering)	• **Justice** (philosophy, public health, business, sociology) • **Finance** (economics, business, international health)	• **Cultural beliefs** (anthropology) • **Ethical values** (philosophy, religion) • **Communications** (psychology, Spanish language skills, humanities)

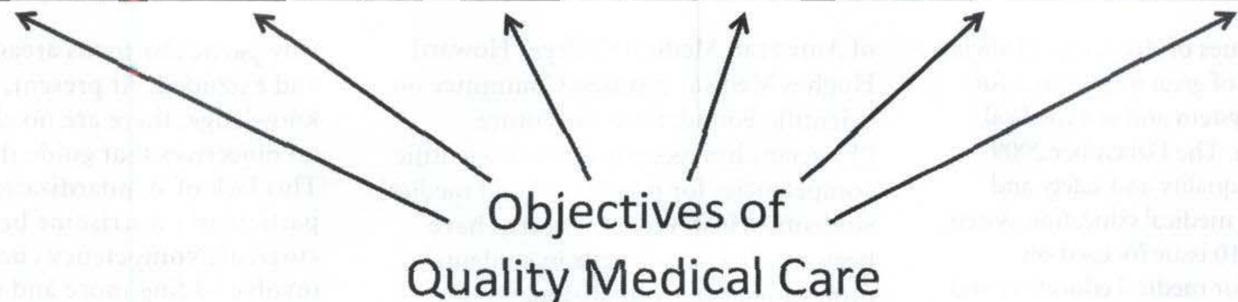
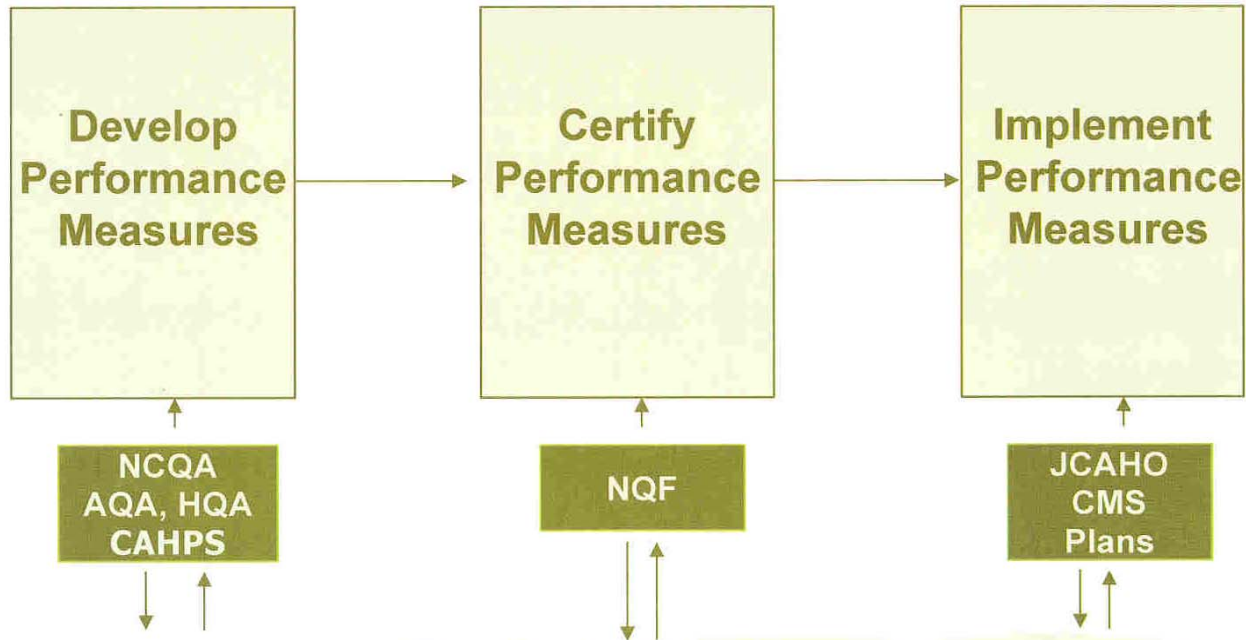


Figure 1 Attributes of the Institute of Medicine quality objectives with related curriculum areas.

A need for unified governance

No American Quality Improvement Community



Multiple Public and Private Sector Stakeholders
100+ different P4P Programs

Source: Tooker/ACP

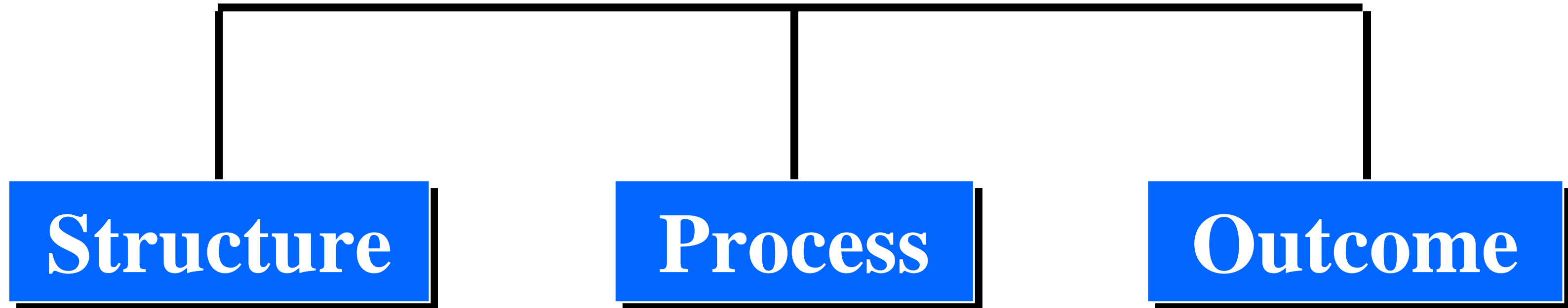
"Unexplained Clinical Variation"

- Major roadblock to:
  - Lowering costs
  - Improving quality
  - Establishing accountability

The Assumption of Financial Risk

- Creates need for accountability.
- Makes me care what my partners order!
- Most importantly, it obviates need for external control.
  - *Yes, but now we have to do it ourselves!*

Old Quality Tripod



Sculpting the Three Faces of Quality

- CQI, TQM
- Re-engineering
- Process Improvement

- Outcomes Management
- Disease Management
- Profiling

- Clinical Guidelines
- Case Management
- Standardization
- Evidence Based Medicine

What is Outcomes Management?

- **Three tiered definition**

Tier One *Outcomes (Traditional)*

- **Morbidity**
- **Mortality**
- **Return to the O.R.**
- **Nosocomial Infections**

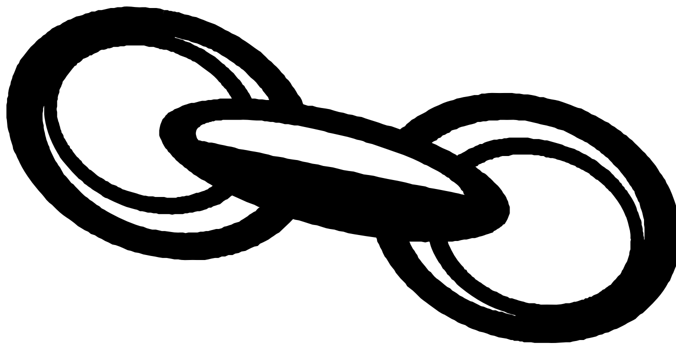
Tier Two *Outcomes (Modern)*

- **Patient satisfaction**
- **Functional status**
- **Return to work**

Tier Three *Outcomes (Ellwood)*

- **Linking tiers one and two to payment**

Tier 1



Tier 2

=

Tier 3

Autonomy and Accountability

A Zero Sum Game?

Nash's Immutable Rule

High Quality Care
Costs Less!

A Real Integrated System

- **Performs no scientifically groundless treatments**
- **Formally searches for effective, proven care practices**
- **Is the safest health care organization**
- **Involves patients and families fully in their own care**
- **Is an open health care organization**

ACT